Health Regulation & Licensing Administration										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		CPA-000033	B. WING		08/1	2/2014				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE						
LATIN AMERICAN YOUTH CENTER 1419 COLUMBIA ROAD NW WASHINGTON, DC 20009										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE				
S 109	An annual licensure August 12, 2014 thr sample sizes were for (5) foster parent redichild records. The survey findings and the review of resurvey findings and the review of resure appear throughout the Child-Placing Agency Program Manager—1612.2 Staff Function Each child-placing a report on the application conditions including adversely affect the with children. This CONDITION is Based on record revisited to ensure each examination report the and physical conditions includes: On August 12, 2014, review of the agency that Employee #3 failexamination on file.	e abbreviations that may ne body of this report. y - CPA PM ns And Qualifications gency shall require a written int's mental and physical addictions which could applicant's capacity to work not met as evidenced by: iew and interview, the CPA in employee had a physical inat included his or her mental ins, for one (1) of five (5) (ree #3) beginning at 1:03 p.m., personnel records revealed led to have a current physical	S 109	Department of Health Regulation & Licensing & Intermediate Care Facilities 899 North Capitol St. Washington, D.C. 20 Washingto	onnel ents be in mental and children. in r. e required	09/15/14 09/14/14 03/2015				
	interview with the pation & Licensing Administration	roll manager, who facilitated	^							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

PRIGRACI

(X6) DATE

If continuation sheet 1 of 2

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Health Regulation & Licensing Administration										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		CPA-000033	B. WING		08/12/2014					
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE						
LATIN AMERICAN YOUTH CENTER 1419 COLUMBIA ROAD NW WASHINGTON, DC 20009										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE					
S 109	Continued From page 1		S 109							
	confirmed that there Employee #3's mer The payroll manage started working with months ago. This i attention of the PM approximately 2:50 he/she would forwa to the surveyor via	urvey, there was no additional								

Health Regulation & Licensing Administration STATE FORM